

## CERTIFICATE OF DEATH

17406

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	2b. HOUR Year		
ELIZABETH R. AYARS				12	12 30 AM		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	2b. HOUR HOURS
FEMALE	WHITE	JULY 6, 1893		73	YRS.		MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH			
NEW YORK	USA			CECIL			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			
ECKTON	UNION HOSP.			HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	12b. KIND OF BUSINESS OR INDUSTRY		
Md.	CECIL	ECKTON	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	RD #4	USA		
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
PORTE V. RANSOM.				ELELYN BYRD HILL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <input type="checkbox"/> unk. <input type="checkbox"/>	16b. SOCIAL SECURITY NO.		17. INFORMANT	Address			
No	NONE		PRESTON AYARS SR.	ECKTON, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>							
DUE TO, OR AS A CONSEQUENCE OF							
4109							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause							
(b) <u>Coronary artery thrombosis</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u>Arteriosclerotic Heart Disease</u>							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
4201							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION	Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>11-8-</u> , 19 <u>68</u> , to <u>12-8-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-8-</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>T. Johnson D. Johnson M.D.</u>				DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>12-9-68</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>123 Sinerly Ave EKTON, MD</u>					
23a. BURIAL, CREMATION (Check one)		23b. DATE <u>12-11-68</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>RIVERVIEW CEM.</u>		23d. LOCATION (City or Town) <u>WILMINGTON, NCARL, DEL.</u>	(County)	(State)
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME Donald De</u>		ADDRESS <u>ECKTON, MD</u>	25a. REC'D. BY REGISTRAR <u>DEC 11 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



17396

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17407

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR		
Catherine Elizabeth Bacigalupo						DEC	19	68	8:30 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)	IF UNDER 1 YEAR			IF UNDER 24 HRS.		
Female	White	4-1-92			76	MDNTHS	DAYS	HDURS	MIN.		
7b. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
N. York	USA				Cecil						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Rising Sun	Calvert Manor N.H.			Domestic							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER							
Md.	Cecil	Rising Sun	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	21 Hakeview Rd.							
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last				
John	K.	Kelly		Elizabeth			Jane				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.			17. INFORMANT	Address						
No	220-54-9681			Calvert Manor N.H. Rising Sun Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN DISEASE AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>										1 Day.	
4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) <u>A.S.H.D. &amp; Generalized Arterosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4200		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
MEDICAL CERTIFICATION							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State			
22a. I certify that (I) (this hospital) attended the deceased from 1967, 19, to Dec, 1968, that (I) (we) lost sow the deceased alive on Dec 15 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Cecil W Seiter M.D.										22c. DATE SIGNED Dec 20, 68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Ernest W. Seiter									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE DEC 23 1968		23c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cemetery		23d. LOCATION (City or Town) Baltimore County		(State)			
24. FUNERAL DIRECTOR Name		ADDRESS Commonwealth Funeral Home			25a. REC'D BY REGISTRAR Date DEC 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

1988.1.10.30

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17397

17408

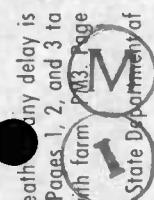
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>MAX</i>	Middle <i>B.</i>	Last <i>BERMAN</i>	2a. DATE OF DEATH Month <i>12</i>	Day <i>27</i>	Year <i>1968</i>	2b. HOUR <i>12 25 P.M.</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>10-27-95</i>		6. AGE (in years last birthday) <i>73</i>		IF UNDER 1 YEAR MONTHS <i>7</i>	IF UNDER 24 HRS. DAYS <i>12</i>
7a. BIRTHPLACE (State or foreign country) <i>Holland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>26 SA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH <i>Cecil County, Elkton</i>				
10. CITY OR TOWN OF DEATH <i>Elkton</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Union Hoop, Elkton</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Chemical</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution before admission) STATE <i>New York</i>	13b. COUNTY <i>New York</i>	13c. CITY OR TOWN <i>New York</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>112 W. 72nd St.</i>			
14. FATHER'S NAME First <i>GEORGE</i>	Middle <i>BERMAN</i>	15. MOTHER'S MAIDEN NAME First <i>JANSJE</i>	Middle <i>SLAGER</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (Unknown) <i>NO</i>	16b. SOCIAL SECURITY NO. <i>136-18-3776</i>	17. INFORMANT <i>HENDRIKA G. BERMAN</i>	Address <i>NEW YORK, N.Y.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5339</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min.</i>			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>5400 Bleeding Peptic ulcer.</i>							
19a. DATE OF OPERATION <i>12-27-68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Bleeding peptic ulcer</i>	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>12-25-1968</i> to <i>12-27-1968</i> , that (I) (we) last saw the deceased alive on <i>12-27-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Cristobal Vela, M.D.</i>		ATTENDING PHYS. DEGREE	<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>12-28-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>CRISTOBAL VELA, M.D.</i>		22e. ADDRESS <i>123 W. High St. Elkton.</i>					
23a. BURIAL, CREMATION, REMOVED (Specify) <i>BURIAL</i>	23b. DATE <i>12-30-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL ESTATE <i>GILPIN MANOR MEM. PH</i>	23d. LOCATION (City or Town) <i>ELKTON, CECIL, Md.</i>	(County) <i>CECIL</i>	(State) <i>Md.</i>		
24. FUNERAL DIRECTOR <i>PIPPIN FUNERAL HOME, Elkton, Md.</i>	ADDRESS <i>Elkton, Md.</i>	25a. REC'D BY REGISTRAR <i>DEC 31 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



FOR STATE  
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. Page 5 may be retained for your files.

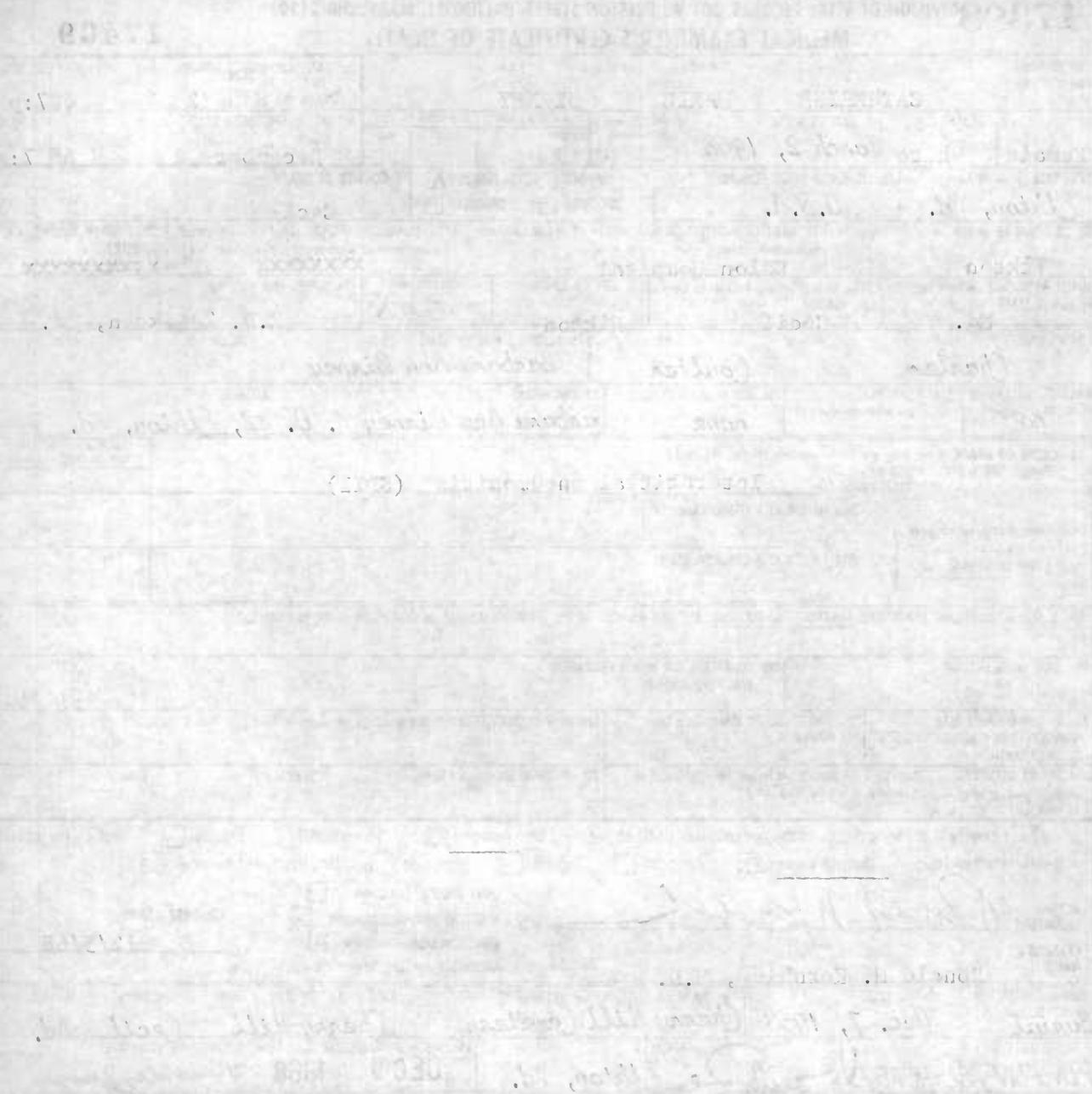
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17398 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17409

1. DECEASED-NAME (Type or Print)			First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
CATHERINE			MARIE	BIRNEY		12	4	19	68 7: p M		
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD				2d. HOUR	
Female	White	March 2, 1968	YRS.	MONTHS	DAYS	MONTH	Day	Year	December 4 1968 7: p M		
9											
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH					
Elkton, Md.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Cecil					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Elkton			Union Hospital			xxxxxxxxxx			xxxxxxxxxx		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Cecil		Elkton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R. D. 2 Elkton, Md.			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost	
Charles				Coulter		Barbara Ann Birney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT			ADDRESS		
no			none			Barbara Ann Birney			R. D. #2, Elkton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis (SDII)</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> } (b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)											
525X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											22b. DATE SIGNED
Ronald N. Kornblum, M.D.											12/5/68
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)		(County)	(State)	
Burial		Dec. 7, 1968		Cherry Hill Cemetery			Cherry Hill		Cecil	Md.	
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
PIPPIN FUNERAL HOME		Dominoe, Elkton, Md.			DEC 9 1968		Charles J. George				
81-06314											



17399

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17410

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED-NAME (Type or print)	First	Middle	Lost	2. DATE OF DEATH Month	2b. HOUR Year
<i>Andrea</i>		<i>Blankenship</i>		12	11 1968 9:20 <sup>30</sup> M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	
<i>Female</i>	<i>White</i>	<i>Dec. 10, 1968</i>		YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH	
<i>Md.</i>	<i>U.S.A.</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>Cecil County</i>	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
<i>ELKTON</i>	<i>Union Hospital</i>			<i>None</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
<i>Md.</i>	<i>Cecil</i>	<i>ELKTON</i>			
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First
<i>Arvil</i>		<i>A. Blankenship</i>		<i>Alma</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT		Address	
<i>No</i>	<i>—</i>	<i>Arvil A. Blankenship R.D.#5 Providence</i>		<i>Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Abruption placenta and prematurity</i>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <i>Approx 30 weeks gestation</i>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<i>30 hrs</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
<i>7615 Shoulder presentation. Delivered by cesarean and extraction</i>					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>12-10-1968</i> to <i>12-11-1968</i> , that (I) (we) last saw the deceased alive on <i>12-11-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	<i>Tillman D. Johnson</i>	22c. DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS		22f. DATE SIGNED		
<i>Tillman D. Johnson</i>	<i>123 Sinerly Ave Elkton, Md.</i>		<i>12-19-68</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town)	(County)	(State)
<i>Burial</i>	<i>12-16-68</i>	<i>Elkton Cem.</i>	<i>Elkton</i>	<i>Cecil</i>	<i>Md.</i>
24. FUNERAL DIRECTOR	ADDRESS	25a. RECEIVED BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
<i>PIPPIE FUNERAL HOME</i>	<i>Elkton, Md.</i>	<i>DEC 16 1968</i>	<i>Charles Judge</i>		

10

Be rational. Be kind.

## ANSWER





## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

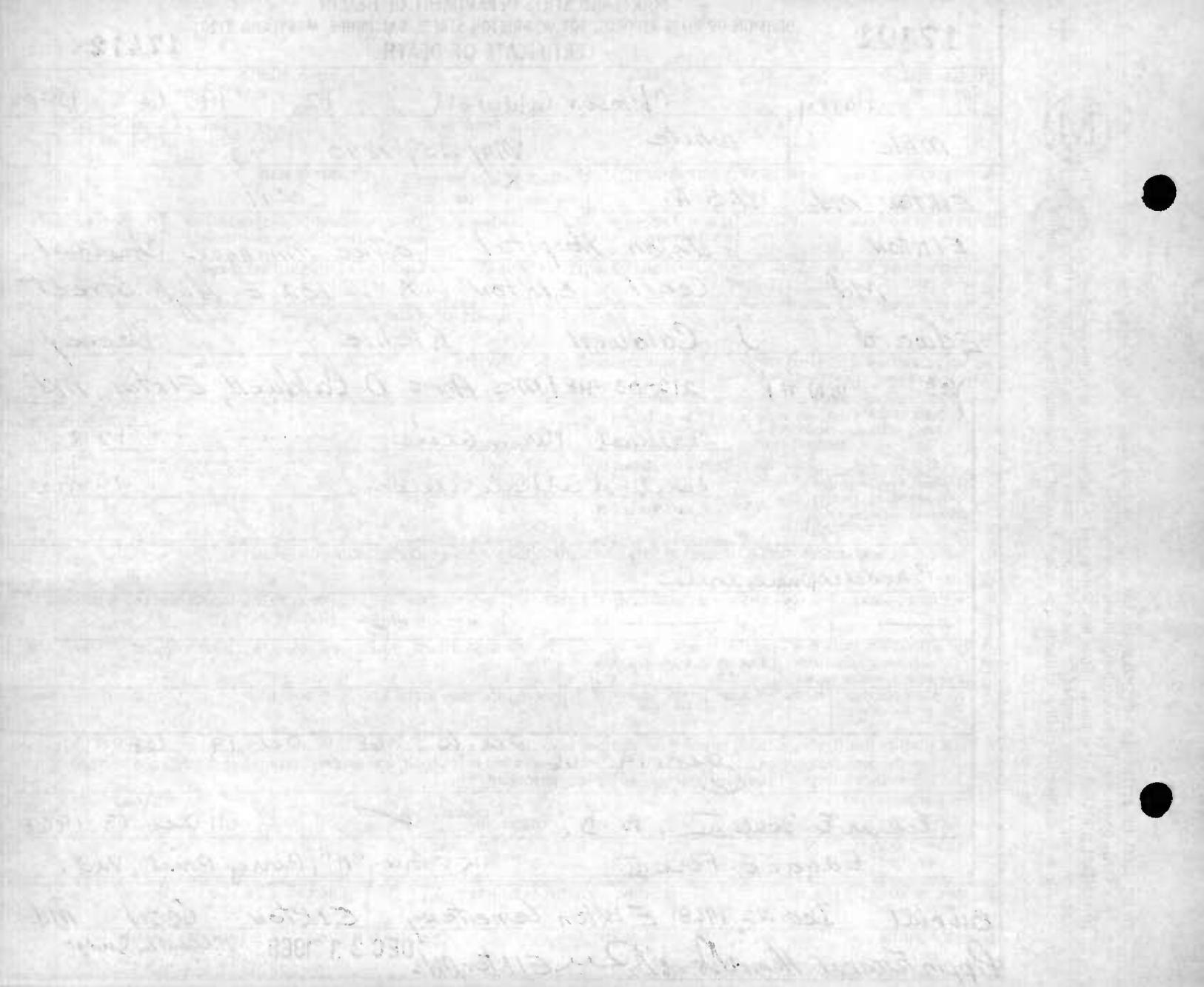
17401

17412

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Please and 2  
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Please and 2  
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First <b>Harry</b>	Middle <b>Clemson Caldwell</b>	Last <b>12</b>	20. DATE OF DEATH Month <b>19</b>	2b. HOUR Year <b>68</b>
3. SEX <b>Male</b>	4. RACE <b>white</b>	S. DATE OF BIRTH <b>MAY 25, 1895</b>	6. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>
7b. BIRTHPLACE (State or foreign country) <b>EIKTON, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Cecil</b>	Md.	
10. CITY OR TOWN OF DEATH <b>EIKTON</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Union Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Office Manager</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Chemical</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>EIKTON</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>132 E. High Street</b>	
14. FATHER'S NAME <b>Edward</b>	First <b>J.</b>	Middle <b>Caldwell</b>	15. MOTHER'S MAIDEN NAME <b>Richie</b>	Middle <b>Denney</b>	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>	16b. SOCIAL SECURITY NO. <b>WN #1</b>	17. INFORMANT <b>Mrs. Arrie D. Caldwell, EIKTON, Md.</b>	Address	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 d.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>					
4339 DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>232</b> (b) <b>Cerebral arteriosclerosis</b>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
10 yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
<b>Bronchopneumonia</b>					
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
—	—		—	—	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 10, 1968</b> , to <b>Dec. 19, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 19, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Edgar E. Folkert, M.D.</b>	22c. DEGREE <b>ATTENDING PHYS.</b>	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <b>Dec. 19, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Edgar E. Folkert</b>	22e. ADDRESS <b>1155 Ave. "A", Perry Point, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 23, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>EIKTON Cemetery</b>	23d. LOCATION (City or Town) <b>EIKTON</b>	(County) <b>Cecil</b>	(State) <b>Md.</b>
24. FUNERAL DIRECTOR <b>Pippin Funeral Home, Donald R. EIKTON, Md.</b>	ADDRESS <b>14149</b>	25a. REC'D BY REGISTRAR <b>DEC 23 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Donald R. EIKTON, Judge</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17402

## CERTIFICATE OF DEATH

17413

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital Of Cecil County</b>		d. STREET ADDRESS <b>216 Hollingsworth Manor</b>	
3. NAME OF DECEASED (Type or print) <b>Mrs. Helen</b>		First <b>E</b>	Middle <b>Coffin</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/22/17</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Cecil Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ernest Moore</b>		14. MOTHER'S MAIDEN NAME <b>Annie Short</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Norman Coffin Jr. (Son)</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>1-Day</b>			
492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Emphysema</b> 2-Years			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>5271</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/19/1968</b> to <b>12/3/1968</b> that (I) (we) last saw the deceased alive on <b>12/3/1968</b> , and that death occurred at <b>6 A.M.</b> from causes and on the date stated above.			
22o. SIGNATURE <i>James L. Johnson</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/3/68</b>
22c. PHYSICIAN'S NAME (Type) <b>James L. Johnson M.D.</b>		22d. ADDRESS <b>245 E. High St., Elkton Cecil Md.</b>	
23o. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/7/68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Elkton Cemetery</b>
24. FUNERAL DIRECTOR <i>Ralph E. Hicks</i>		ADDRESS <b>Hicks Home For Funerals, Elkton, Md.</b>	25o. REC'D BY REGISTRAR <b>DEC 13 1968</b>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

6751

1000-10-1100002

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
17403 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17414

1. DECEASED-NAME (Type or Print)	First <b>FELIX</b>	Middle	Lost <b>COLLAZO</b>	20. DATE KNOWN OF DEATH ESTIMATED MATED	Month <b>12</b>	Day <b>21</b>	Year <b>1968</b>	2b. HOUR <b>6890 P.M.</b>			
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>10/10/46</b>	6. AGE (In years last birthday) <b>22</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	HOURS <b>0</b>	MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>12</b>	Day <b>21</b>	Year <b>1968</b>	2d. HOUR <b>950 P.M.</b>
7a. BIRTHPLACE (State or foreign country) <b>TOA ALTA, PUERTO RICO</b>	7b. CITIZEN OF WHAT COUNTRY? <b>PUERTO RICO</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH <b>CECIL</b>	10. CITY OR TOWN OF DEATH <b>ELKTON, MD</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Union Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>musical room LABOREK</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>AGRICULTURE</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Penna</b>	13b. COUNTY <b>CHESTER</b>	13c. CITY OR TOWN <b>Kennett Square</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER <b>ADDRESS 333 ARCH ST</b>							
14. FATHER'S NAME <b>HERMeregildo</b>	First	Middle	Lost <b>COLLAZO</b>	15. MOTHER'S MAIDEN NAME <b>AVELINA</b>	First	Middle	Lost <b>RODRIGUEZ</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16b. SOCIAL SECURITY NO. <b>583-09-9382</b>	16c. INFORMANT <b>APOLONIO COLLAZO</b>	16d. ADDRESS <b>CAMDEN, NEW JERSEY 08102</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Injuries</b> DUE TO, OR AS A CONSEQUENCE OF <b>8121</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>8164</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>950 P.M.</b>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>12/21 1968</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>passenger of auto involved in collision.</b>			20. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>RT 280 Road</b>			21f. LOCATION Street or R.F.D. No. City or Town <b>RT 280, 3/4 mile south of PA state line, MD</b>			County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Werner L. Spitz, M.D.</b>				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>WERNER L. SPITZ, M.D.</b>				M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22b. DATE SIGNED <b>12.22.68</b>											
ADDRESS (Street, city, town, or county) <b>TOA ALTA, PUERTO RICO</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12-27-68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>TOA ALTA</b>				23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>PIPPIN FUNERAL HOME</b>		ADDRESS <b>ELKTON</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 30 1968</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

DEC 30 1962



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## CERTIFICATE OF DEATH

17416

**NO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial/cremation, or removal, and in any event, within 72 hours of the death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

17417

1. DECEASED-NAME (Type or print)		First <b>LEE</b>	Middle <b>Unk</b>	Lost <b>DUNCAN</b>	20. DATE OF DEATH Month <b>DECEMBER</b>	Day <b>4</b>	Year <b>1968</b>	2b. HOUR pm <b>11:05</b>													
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>MAY 18, 1911</b>		6. AGE (In years last birthday) <b>57</b>		IF UNDER 1 YEAR MONTHS <b>YRS.</b>													
7. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CECIL</b>		IF UNDER 24 HRS. HOURS <b>Md.</b>													
10. CITY OR TOWN OF DEATH <b>PERRY POINT</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VA HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>		14. FATHER'S NAME First <b>Jackson</b>		15. MOTHER'S MAIDEN NAME First <b>Fannie</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service) <b>Yes</b> <b>WW II</b>		17. SOCIAL SECURITY NO. <b>230-10-8836</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignancy from unknown primary site</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>1991</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1992</b>		19. DATE OF OPERATION <b>1992</b>		20. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <b>VA</b>		City or Town		County		State					
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 2, 1968</b> , to <b>Dec. 4, 1968</b> , <input type="checkbox"/> <b>XX</b> <input type="checkbox"/> <b>XX</b> <input type="checkbox"/> <b>XX</b> XXXXXX the deceased died <input type="checkbox"/> <b>19</b> <input type="checkbox"/> <b>XX</b> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> we <input type="checkbox"/> did <input type="checkbox"/> <b>XX</b> <input type="checkbox"/> <b>XX</b> view the body after death.		22b. SIGNATURE <b>E. E. FOLK III, M.D.</b>		22c. DATE SIGNED <b>12-5-68</b>																	
22d. PHYSICIAN'S NAME (Type) <b>E. E. FOLK III, M.D.</b>		22e. ADDRESS <b>VA Hospital, Perry Point, Md.</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12-6-68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Berkeville Cemetery</b>		23d. LOCATION (City or Town) <b>Berkeville,</b>		(County)		(State)											
24. FUNERAL DIRECTOR <b>Phillips Funeral Home, Baltimore, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>															

**NO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17407

17418

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>CORNELL</i>	Middle <i>EBANKS</i>	Lost	20. DATE OF DEATH 12 Month 2 Day 60 Year	2b. HOUR	
3. SEX <i>M</i>	4. RACE <i>W</i>	S. DATE OF BIRTH <i>10-24-43</i>		6. AGE (In years last birthday) <i>75</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>WEST INDIKS</i>	7b. CITIZEN OF WHAT COUNTRY? <i>M.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH <i>CECIL</i>			
10. CITY OR TOWN OF DEATH <i>ELSTON</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>UNION HOSPITAL</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>RET. CARPENTER</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>SELF</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>M.D.</i>	13b. COUNTY <i>CECIL</i>	13c. CITY OR TOWN <i>CHESAPEAKE CITY</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER —		
14. FATHER'S NAME First <i>DECES</i>	Middle <i>EBANKS</i>	15. MOTHER'S MAIDEN NAME First <i>ROCHCHESTER</i>	Middle <i>YATES</i>	Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. If yes give war or dates of service) —	17. INFORMANT <i>MRS. MARIE EBANKS</i>	Address <i>CHESAPEAKE CITY, MD.</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Vascular Failure</i>						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>150 X</i>						
(b) <i>Pneumonia and Lung Metastasis</i> 7 months						
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Inoperable La of esophagus</i> 1 year						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Multiple La metastasis - G.A.S. C/A.S. CVD</i>						
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>10-27, 1968</i> , to <i>12-2, 1968</i> , that (I) (we) last saw the deceased alive on <i>12-7-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Luis M. Cuza M.D.</i>	22c. DEGREE <i>M.D.</i>	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>12-3-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Luis M. Cuza, M.D.</i>	22e. ADDRESS <i>322 E. Cecil Ave. North East, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>12-5-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>BETHEL</i>	23d. LOCATION (City or Town) <i>CHESAPEAKE CITY</i>	(County) <i>CECIL</i>	(State) <i>MD</i>	
24. FUNERAL DIRECTOR <i>R.T. FOARD FUNERAL HOME CITY, MD.</i>	ADDRESS <i>CHESAPEAKE CITY, MD.</i>	25a. REC'D BY REGISTRAR DATE <i>DEC 4 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Magee</i>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 5 may be retained for your files.

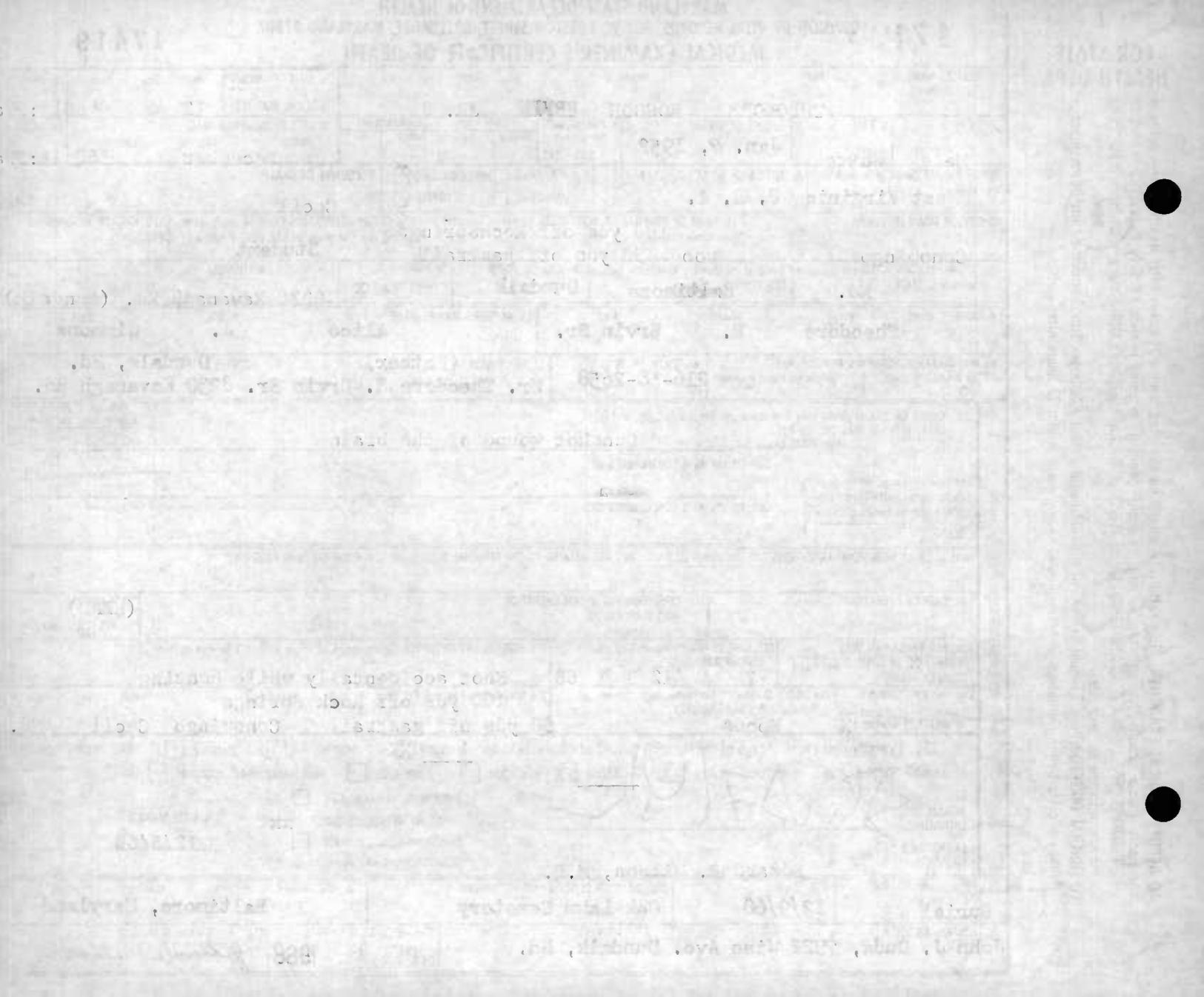
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
17418 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17419

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)	First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR
THEODORE ROSCOE ERVIN JR.				<input checked="" type="checkbox"/>	12	4	19	6811:50
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS			2d. HOUR
Male	White	Jan. 7, 1952	16 YRS.	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH				
West Virginia	U. S. A.	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Cecil				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY			
Conowingo	100 yds off Rock Springs woods 50 yds off gastral			Student				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
Md.	Baltimore	Dundalk	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	8230 Kavanagh Rd. (Dundalk)				
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost	
Theodore	R.	Ervin Sr.		Alice	J.	Simmons		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT (Father)			ADDRESS			
No	216-58-2658	Mr. Theodore R. Ervin Sr. 8230 Kavanagh Rd.			Dundalk, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Gunshot wound of the brain</u>								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. 9229								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Car</u>								
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 919.8								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						
		20. AUTOPSY? HEAD? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. ? P.M. 12 3 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot accidentally while hunting				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Woods		21f. LOCATION (Street or R.F.D. No. City, Town, County, State) 100 yds off Rock Springs 50 yds off gastral Conowingo Cecil Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Edward F. Wilson, M.D.</u>								
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/9/68		23c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 9 1968		25b. REGISTRAR'S SIGNATURE <u>John J. Duda</u>		



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

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17409

17420

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Matthew</i>	Middle <i>Ficklin</i>	Last <i>Ficklin</i>	2a. DATE OF DEATH Month <i>Dec.</i>	Day <i>28</i>	Year <i>1968</i>	2b. HOUR <i>M</i>	
3. SEX <i>Male</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>Aug. 23, 1890</i>		6. AGE (In years last birthday) <i>78</i>		7. IF UNDER 1 YEAR MONTHS <i>00</i>		
7a. BIRTHPLACE (State or foreign country) <i>Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Cecil</i>		8. IF UNDER 24 HRS. MONTHS <i>00</i>		
10. CITY OR TOWN OF DEATH <i>Port Deposit</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Rt. 222</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Cecil</i>	13c. CITY OR TOWN <i>Port Deposit</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>Rt. 222</i>			
14. FATHER'S NAME First <i>Unknown</i>	Middle <i></i>	Lost <i></i>	15. MOTHER'S MAIDEN NAME First Middle <i>Unknown</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> no <input type="checkbox"/> or unknown	16b. SOCIAL SECURITY NO. <i>218-52-2971</i>	17. INFORMANT <i>Social Services Records, Elkton, Md.</i>	Address <i></i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Alzheimers - Sclerosis - Cardiovascular</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>		
4129 Conditions, if any, which gave rise to immediate cause (a). stating the <u>underlying cause</u> lost.								
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4221 Multiple Orthopedic, Chronic Bronchitis</i>								
19a. DATE OF OPERATION <i>4221</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY. OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 6, 1968</i> , to <i>12/27, 1968</i> , that (I) (we) last saw the deceased alive on <i>12/27, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Clarence I. Benson</i>		DEGREE <i></i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>12/29/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Clarence I. Benson, M. D.</i>		22e. ADDRESS <i>Port Deposit, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1-1-1969</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Baptist Church Cemetery</i>	23d. LOCATION (City or Town) <i>Port Deposit, Cecil Md.</i>	(County) <i>Cecil</i>			(State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>Charles J. Ingles</i>		ADDRESS <i>117 Main Street, Sykesville, Md.</i>		25a. REC'D BY REGISTRAR <i>Jan 7, 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Ingles</i>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17410

CERTIFICATE OF DEATH

17421

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH December 3, 1968	2b. HOUR 8:35 A.M.
THOMAS H. FIELDS, SR.						
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>June 9, 1892</b>		6. AGE (In years lost birthday) <b>76</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Cecil</b>
10. CITY OR TOWN OF DEATH <b>Perry Point</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VA Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Trackman - Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Port Deposit</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <b>WILLIAM J. FIELDS</b>		Middle	Lost	15. MOTHER'S MAIDEN NAME First <b>HANNA P. BROWN</b>		Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>WW I 717 07 56 44</b>		17. INFORMANT <b>VA Records, VAH, Perry Point, Maryland</b>		Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>4510</b>		Massive pulmonary embolus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Phlebothrombosis of deep leg veins, rt. side				
		DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <b>463X Arteriosclerotic coronary heart disease with generalized debility</b>						
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
						20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County
						State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10-21- 1968</b> , to <b>12-3- 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12-3- 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (will) view the body after death.						
22b. SIGNATURE <b>A. L. Mooney, M.D.</b>						
22c. DATE SIGNED <b>12-3-68</b>						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
<b>A. L. MOONEY, M.D.</b>		<b>Path.</b>		<b>VA Hospital, Perry Point, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL		23b. DATE <b>12-3-68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cokesberry, Md.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cokesberry, Cecil Md.</b>
24. FUNERAL DIRECTOR <i>and Patterson &amp; Son</i>		ADDRESS				25a. REGD BY REGISTRAR DATE <b>DEC 6 1968</b>
						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

3041, 15, 2000

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## CERTIFICATE OF DEATH

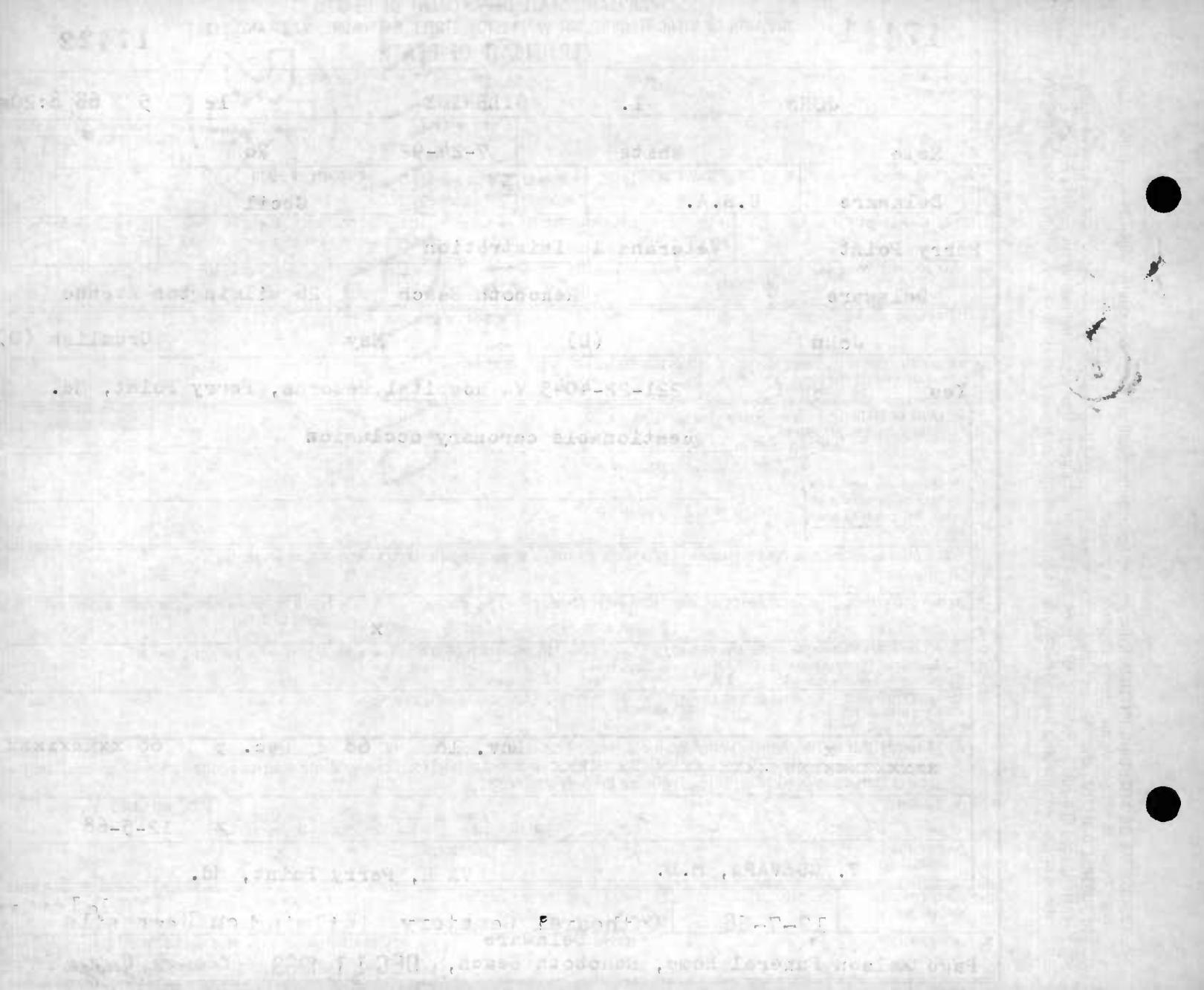
17422

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR				
JOHN		I.	GILBRIDE		Month	12	Day	5	Year	68	8:20
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		7-24-92		76		MONTHS	YEARS	HOURS	MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
Delaware		U.S.A.				Cecil					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Perry Point		Veterans Administration		Rehoboth Beach		26 Wilmington Avenue					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Delaware				Rehoboth Beach		YES <input type="checkbox"/> NO <input type="checkbox"/>		26 Wilmington Avenue			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
		John		(D)			May		Crumlish	(D)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) WW I		17. INFORMANT		Address					
				221-22-4045 VA Hospital Records, Perry Point, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Questionable coronary occlusion											
4109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that (X) (this hospital) attended the deceased from Nov. 18, 1968, to Dec. 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		ATTENDING PHYS.			MED. DIRECTOR		STAFF PHYS.		22c. DATE SIGNED		
T. GUEVARA, M.D.									12-5-68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			VA H, Perry Point, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIALY		23d. LOCATION (City or Town)		(County) Deale			
12-7-68				Cathedral Cemetery		Wilmington Newcastle					
24. FUNERAL DIRECTOR		ADDRESS Delaware			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Page Nelson					DEC 11 1968		Charles Judge				
Page Nelson Funeral Home, Rehoboth Beach, Del.											

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 HOSPITAL OR ATTENDING PHYSICIAN:** We now require that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**11 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



17423

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or Print)		First	Middle	Last	20. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR					
CLARENCE		GOAD			12	5	19	68	11:11					
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS      DAYS	IF UNDER 24 HRS. HOURS      MIN.	2c. DATE PRONOUNCED DEAD Month      Day      Year								
Male	White	Feb. 7, 1912	56 yrs.			December	5, 19	68	11:11					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH								
Virginia		U.S.A.				Cecil								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY								
North East		Off R.R. 7 near North East		On Carbon Lane in trailer		University of Del employee								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER								
Del.		New Castle		Wilmington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	824 W. 9th St.							
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Lost						
Harvey		Goad			Rosa			Bolt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS								
Yes		WW 2		Mr. Edgar Goad, North East, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardio- vascular disease														
4120 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> (b) last.      (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
443X		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?										
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. AUTOPSY?												
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M.      P.M.      19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE		Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED								
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		12/6/68								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL Goad Cemetery	23d. LOCATION (City or Town)	(County)	(State)
24. FUNERAL DIRECTOR Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.										ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
										DEC 13 1968	Charles Judge			



17413

## CERTIFICATE OF DEATH

Reg. Dist. No. 17424

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City,		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anderson		First Jackson	Middle Greene	4. DATE OF DEATH 12 - 26	Month 1968	Day	Year
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March, 21, 1906		9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Greene				14. MOTHER'S MAIDEN NAME Martha J. Allen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-12-3173		INFORMANT Mrs. John Hessey, Chesapeake City, Md. 21915		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO (c) DUE TO Chronic Pulmonary Insufficiency Chronic Emphysema						INTERVAL BETWEEN ONSET AND DEATH SEVERAL YEARS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
527.1		19		1277		1277	
21. I certify that I attended the deceased from 1277, 1968 to 1277, 1968, that I last saw the deceased alive on 1277, 1968, and that death occurred at 1277, 1968, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Harvey V. Davis							
PHYSICIAN'S NAME (Type) Harvey V. Davis 40		CHESAPEAKE CITY 1277, 1968					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 29, 1968		22c. NAME OF CEMETERY OR CREMATORIUM Johnstown Cemetery		22d. LOCATION (City, town, or county) Earleville, Cecil, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows & Son, Millington, Md. 21651				ADDRESS		24a. REC'D BY REGISTRAR DEC 30 1968	
						24b. REGISTRAR'S SIGNATURE Charles Judge	

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4 FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17414

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17425

1. PLACE OF DEATH a. COUNTY Cecil			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN lb DOA			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Northeast					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital			d. STREET ADDRESS RD # 1			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Albert			First AKA	Middle J	Last Grussenmeyer	4. DATE OF DEATH 12-19-1968			Month	Day	Year
S. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/12/1895	9. AGE (In years last birthday) 73 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming			11. BIRTHPLACE (State or foreign country) Delaware	12. CITIZEN OF WHAT COUNTRY? USA	IF UNDER 1 YEAR Months Days Hours Min.
13. FATHER'S NAME Nicholas Grussenmeyer			14. MOTHER'S MAIDEN NAME Anna May Meyer			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI			16. SOCIAL SECURITY NO. 218 18 8818 17. INFORMANT Mr. Joseph N. Mahoney Wilm. Del.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH Years		
4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO (b)											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 4200											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 12-19-68		
ACTUAL SIGNATURE <u>William Johnson</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>William Johnson M.D.</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12/23/1968</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Wilmington N.C. Del.</u>		
24. FUNERAL DIRECTOR <u>William J. Warwick</u>			ADDRESS <u>100 W. 12th Street Newark, Delaware</u>			25a. REC'D BY REGISTRAR <u>JAN 3</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17415

17426

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED-NAME (Type or print)		First <b>Joseph</b>	Middle <b>Robertson</b>	Last <b>Haines</b>	2a. DATE OF DEATH Month <b>Dec.</b>	2b. HOUR Year <b>1968</b>
3. SEX <b>Male</b>	4. RACE <b>Colored</b>	5. DATE OF BIRTH <b>3-6-1881</b>		6. AGE (In years last birthday) <b>87</b>	2b. HOUR IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <b>Cecil Co. Md.</b>			
10. CITY OR TOWN OF DEATH <b>Conowingo Md.</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>R.F.D. #1</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Labor</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Flintmill</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>Conowingo</b>	13d. INSIDE CITY LIMITS? <b>YES</b>	13e. STREET AND NUMBER <b>R.F.D. # 1</b>		
14. FATHER'S NAME <b>Joseph</b>	First <b>Haines</b>	Middle <b></b>	Last <b>Maria</b>	Middle <b>Barnes</b>	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>NO</b>	16b. SOCIAL SECURITY NO. <b>213-12-5640A</b>	17. INFORMANT <b>Samuel Haines</b>	Address <b>Conowingo, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						
PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>						
DUE TO, OR AS A CONSEQUENCE OF <b>A S.H.O.</b>						
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF <b>5 yrs.</b>						
(b)						
(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
4201						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>Dec.</b> Day <b>12</b> Year <b>P.M.</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>5-6</b> , 19 <b>67</b> , to <b>12-7</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-7</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Neil R. Taylor Jr.</b>		DEGREE <b></b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>12-9-68</b>
22d. PHYSICIAN'S NAME (Type) <b>Neil R. Taylor Jr.</b>		22e. ADDRESS <b>Rising Sun, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-11-1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Zoar Cem.</b>	23d. LOCATION (City or Town) <b>Conowingo</b>	(County) <b>Cecil</b>	(State) <b>Md.</b>
24. FUNERAL DIRECTOR <b>Jernome E. M. Muller</b>		ADDRESS <b>Rising Sun, Md.</b>	25a. REC'D BY REGISTRAR <b>DEC 12 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
VR A15 (4) 30M REV. 1-68						



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17427

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		17416						2	
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH December 14 Day 1968 Year		2b. HOUR 1:10 PM		
Dorothy M. Hanna									
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec. 24, 1885		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED		9. COUNTY OF DEATH Cecil			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Perryville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.D. # 1	
14. FATHER'S NAME Steven Hickman		15. MOTHER'S MAIDEN NAME Mary Jewel							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 208-12-9453		17. INFORMANT Mrs. Mary Sibley		Address R.D. # 1 Perryville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4129</u> (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Thoracic &amp; abdominal aortic aneurism.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-9</u> 19 <u>68</u> , to <u>12-14</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-13</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>J.S. Barnhart Jr. M.D.</u>		22c. DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 4 Mauldin Ave. North East, Md.		22c. DATE SIGNED 12-14-68					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-18-68		23c. NAME OF CEMETERY OR CREMATORIUM Montrose Cemetery		23d. LOCATION (City or Town) Highland Park		(County) (State) Delaware Pa.	
24. FUNERAL DIRECTOR Grant Funeral Home		ADDRESS BOX 22 North East Md.		25a. RECD BY REGISTRAR DATE DEC 18 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

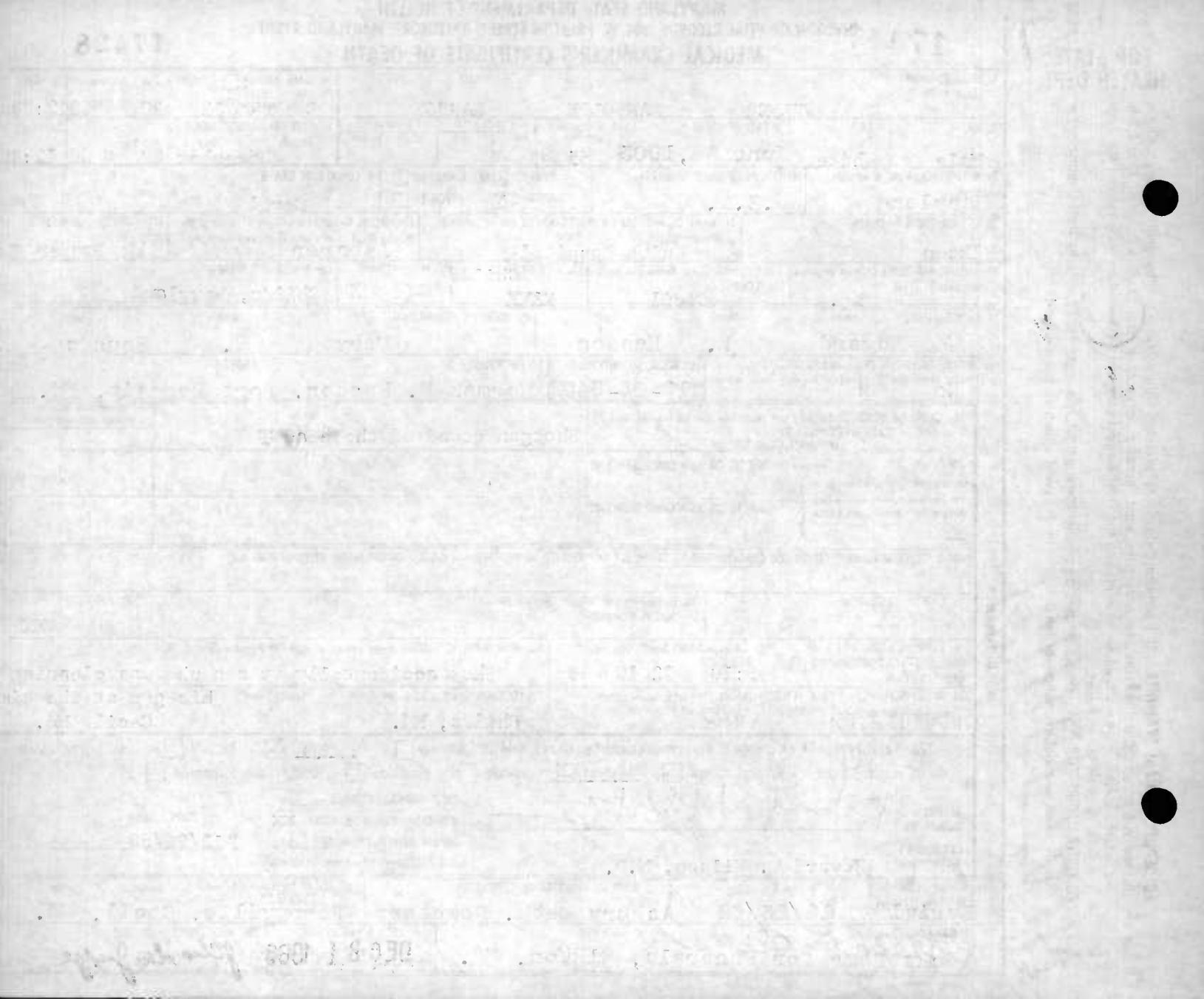
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17428

DECEASED-NAME (Type or Print)	First	Middle	Lost	20. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR		
WILMER RANDOLPH HASSON				<input type="checkbox"/>	12	20	1968	12:20a		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS					
Male	White	June 18, 1903	65 YRS.	MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland	U.S.A.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Cecil					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY		
Elkton	Union Hospital			Laborer				Elk Paper Co		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER						
Md.	Cecil	Childs	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	Childs, Maryland						
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost			
Edward	P.	Hasson		Mary	E.	Founds				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT			ADDRESS					
No	212-03-5402	Norman H. Hasson, Port Deposit, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of the abdomen										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR AM 9:10 M 12 19 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot accidentally by son who was cleaning						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No.		City or Town			his gun at the time Cecil Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE									CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)									ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Edward F. Wilson, M.D.									DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Asbury Meth. Cemetery			23d. LOCATION (City or Town) (County) (State)			
Burial		12/23/68					near Perryville, Cecil, Md.			
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Ralph E. Hicks		Hicks Home for Funerals, Elkton, Md.			DEC 31 1968		Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1-3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17418

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17429

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
CECIL MARYLAND		MARYLAND CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 5 MONTHS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WARWICK		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATHRYN		First L.	Middle
4. DATE OF DEATH HEVERLOW		Month DEC	Day 14 Year 1968
5. SEX F		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH JAN 19 1904		9. AGE (In years lost birthday) 64 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME CHARLES		14. MOTHER'S MAIDEN NAME ETTA TAYLOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 212-14-0696	17. INFORMANT HOSPITAL RECORDS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LIVER AND STOMACH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 193X } (b) CARCINOMA OF STOMACH DUE TO (c) UNKNOWN			
INTERVAL BETWEEN ONSET AND DEATH SEVERAL MONTHS UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) ENCOURAGED RT. FENOR - 3/9/68			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) FELL IN FLOOR AT HOME FRONT	
20c. TIME OF INJURY Month, Day, Year 10 AM 3/9 1968		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME
20f. (City or town) WARWICK		(County) CECIL	
(State) MD			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Henry V. Davis</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) HENRY V. DAVIS MD		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 17, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Johnstown Cemetery.
23d. LOCATION (City or Town) EARLEVILLE,		(County) CECIL	
(State) MD			
24. FUNERAL DIRECTOR Edward Fellows & Son, Millington, Md. 21651		ADDRESS	25a. REC'D BY REGISTRAR DEC 20 1968
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

2242

1963-1964

1963-1964

838 (1338) 1963-1964

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17419 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17430

1. DECEASED NAME (Type or Print)	First GEORGE	Middle William	Lost HUGHES	2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Dec. 7, 1968	Month Year P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Dec. 7, 1945	6. AGE (In years last birthday) 23 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2b. HOUR 1683:00 P.M.
7a. BIRTHPLACE (State or foreign country) Darlington, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Cecil	2c. DATE PRONOUNCED DEAD Month Dec. 7, 1968	12d. HOUR 683:00 P.M.	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Buyer	12b. KIND OF BUSINESS OR INDUSTRY Logging			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13c. CITY OR TOWN Harford	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER Unk.			
14. FATHER'S NAME John H. Hughes	15. MOTHER'S MAIDEN NAME Catherine C. Schumm					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <small>(Yes, no, or unknown) 1965</small>	16b. SOCIAL SECURITY NO. 213-42-3556	17. INFORMANT Mrs. John H. Hughes	ADDRESS Darlington, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. <b>910.9</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>9298</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21b. TIME OF INJURY Month, Day, Year HOUR A.M. Unk. P.M. 12-4- 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Drowning while duck hunting</b>		
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Water</b>		21f. LOCATION Street or R.F.D. No. Unk. City or Town Unk. County Cecil State M.D.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Ronald N. Kornblum</i>	EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE Dec. 11, 1968	23c. NAME OF CEMETERY OR CREMATORIAL <b>Darlington Cemetery</b>	23d. LOCATION (City or Town) <b>Darlington, Harford Co. Md.</b>	(County)	(State)	
24. FUNERAL DIRECTOR John H. Harkins	ADDRESS Delta, Pa.	25a. REC'D BY REGISTRAR DATE DEC 12 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

John W. Reid

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of

**10 TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**17420 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17431

1. DECEASED-NAME (Type or Print)			First	Middle	Lost	20. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
JAMES W. HUMPHRY						12	12	68	?		
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD				2d. HOUR	
M	W.	5-17-94	73	MONTHS	DAYS	MONTH	Day	Year	M		
7. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH					
DEL.		U. S. A.		WIDOWER <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	CECIL					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CEASAPEAKE CITY			GEORGE ST			BARBER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
MD			CECIL CHESAPEAKE CITY		NO		GEORGE ST NEAR 3RD				
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
GEORGE W. HUMPHRY						ANNIE			E. GEARY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
YES			NONE		GEORGE M. HUMPHRY		CECILTON, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Coronary Thrombosis											
DUE TO, OR AS A CONSEQUENCE OF											
4109											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Open C. Artery (c) SEVERAL Hours YEARS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year August 8th 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) FUNDIN BED AT HOME						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, town, street, factory, office, building, etc.) AT HOME		21f. LOCATION Street or R.F.D. No. GEORGE CHESAPEAKE CECIL MD.						
22a. I certify that I took charge of the remains described above, held on			Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion		
death resulted from: Natural causes <input checked="" type="checkbox"/>			Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE			M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
HENRY V. DAVIS MD					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)		12/17/68		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		12-15-68		CECILTON		CECILTON CECIL MD.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
R. T. FOARD FUNERAL HOME		CHESAPEAKE CITY MD		DATE DEC 16 1968		Charles Judge					



FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17421 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17432

1. DECEASED-NAME (Type or Print)			First NED	Middle VERNON	Last JOHNSON	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 12/14	Month 1968	Day	Year	2b. HOUR 11:30 p.m.	
3. SEX male	4. RACE white	S. DATE OF BIRTH 2-18-32	6. AGE (in years last birthday) 36 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD Month December Day 15, Year 1968 2d. HOUR 12:10 A.M.			
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil			
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL OR INSTITUTION. (If not in hospital give street address) Union Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Moz-Mercan		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD #1, Linton Run Road		Md.			
14. FATHER'S NAME Harry			15. MOTHER'S MAIDEN NAME E. Johnson, Jr.			16. SOCIAL SECURITY NO. 132-37-0000			17. INFORMANT Arkansas M. Irene Johnson, Post Deposit Rd.		
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Multiple Injuries</b>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a). stating the <u>underlying cause</u> } (b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
20. MEDICAL CERTIFICATION			21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21c. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOURS 11:30 A.M. 12/14/68			21d. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) Driver of car, struck embankment, thrown from car			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) street			21f. LOCATION Street or R.F.D. No. Belvedere Rd & Rte. 40,			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
22a. I certify that I took charge of the remains described above, held an			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Werner U. Spitz, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 12/16/68		
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE 12/19/68			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Principia Cemetery, Linnville, Cecil Md.			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR See J. Patterson, Linnville, Md.						25a. READ BY REGISTRAR DATE DEC 30 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

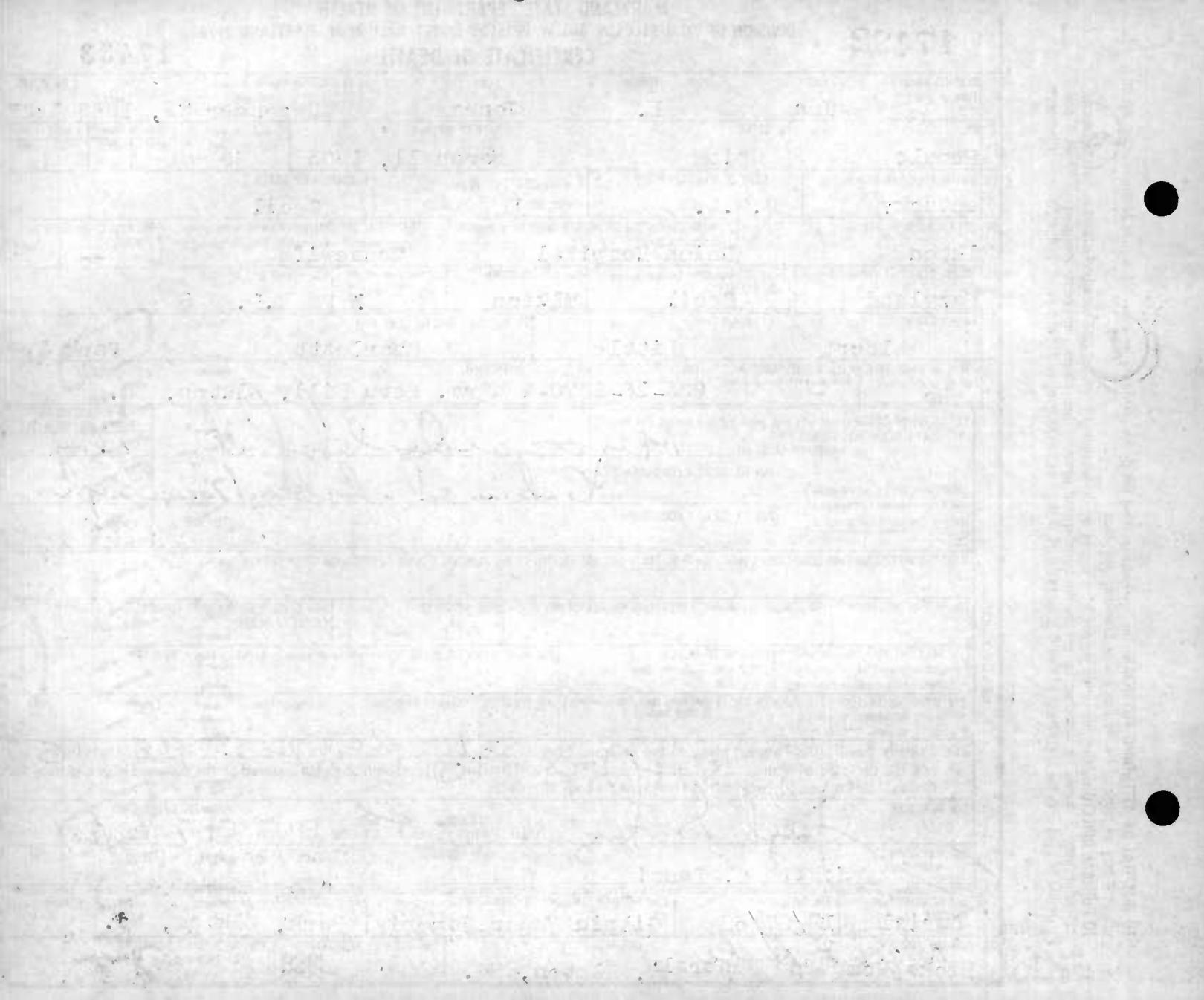
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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Ida	Middle L.	Last Jones	2a. DATE OF DEATH Month December	2b. HOUR Day 22, 1968 Year 7:32	
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 11, 1903		6. AGE (In years last birthday) 65 yrs.	
7a. BIRTHPLACE (State or foreign country) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.D. # 5	
14. FATHER'S NAME First Albert		Middle Little	Last	15. MOTHER'S MAIDEN NAME First Charlotta		Middle Last Park	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 235-26-3370-A		17. INFORMANT Mrs. Peru Hill, Elkton, Md.		Address	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 1 day 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. <i>Cecilis sclerotic heart disease sign.</i></p> <p>(b) _____ DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) _____</p>							
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>4201</p>							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
<p>22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 17, 1968</i>, to <i>Dec 22, 1968</i>, that (I) (we) lost sow the deceased alive on <i>12/22/68</i> and that in <u>my</u> (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>							
22b. SIGNATURE <i>Joseph G. Tanzi</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>12/26/68</i>		
22d. PHYSICIAN'S NAME (Type) Joseph G. Tanzi		22e. ADDRESS Elkton Medical Park Elkton, Maryland 21921					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/27/68	23c. NAME OF CEMETERY OR CREMATORIAL Gilpin Manor Memorial		23d. LOCATION (City or Town) Park, Elkton, Md.	(County) Elkton	(State)
24. FUNERAL DIRECTOR <i>Ralph E. Hicks</i>		ADDRESS Hicks Home for Funerals, Elkton, Md.		25a. RECD BY REGISTRAR DATE IAN 9 1969	25b. REGISTRAR'S SIGNATURE <i>Charles George</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17434

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. DECEASED NAME (Type or print) Anna		First	Middle	Last	2a. DATE OF DEATH December Month 2 Day 1968 Year	2b. HOUR 3:35 p.m.
3. SEX female	4. RACE white	5. DATE OF BIRTH 10-10-1883 ?			6. AGE (In years at death) 85	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Talbot, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Cecil		
10. CITY OR TOWN OF DEATH Rising Sun, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert Manor Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY TALBOT	13c. CITY OR TOWN Sherricos	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
14. FATHER'S NAME First John	Middle E.	Last Willsey	15. MOTHER'S MAIDEN NAME Chambers	Middle	Last Sarah	
16a. WAS DECEASED EVER Yes, no, or unknown	IN U.S. ARMED FORCES? (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 218-20-2856	17. INFORMANT William Burkhardt	Address Rd. 2, Elkton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> 437.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> } last. (b) <i>cerebral arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 10 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 11-1, 1968, to 12-2, 1968, that (I) (we) last saw the deceased alive on 12-1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Dr. Neil Taylor</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 12-3-68
22d. PHYSICIAN'S NAME (Type) Dr. Neil Taylor		22e. ADDRESS Rising Sun, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12/5/1968	23c. NAME OF CEMETERY OR CREMATORY Spring Hill	23d. LOCATION (City or Town) (County) (State) Easton, Md.		
24. FUNERAL DIRECTOR MURICE E. NEARY, INC., EASTON, MD		ADDRESS	25a. REC'D BY REGISTRAR DEC 5 1968		25b. REGISTRAR'S SIGNATURE <i>Glenda J. Jones</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

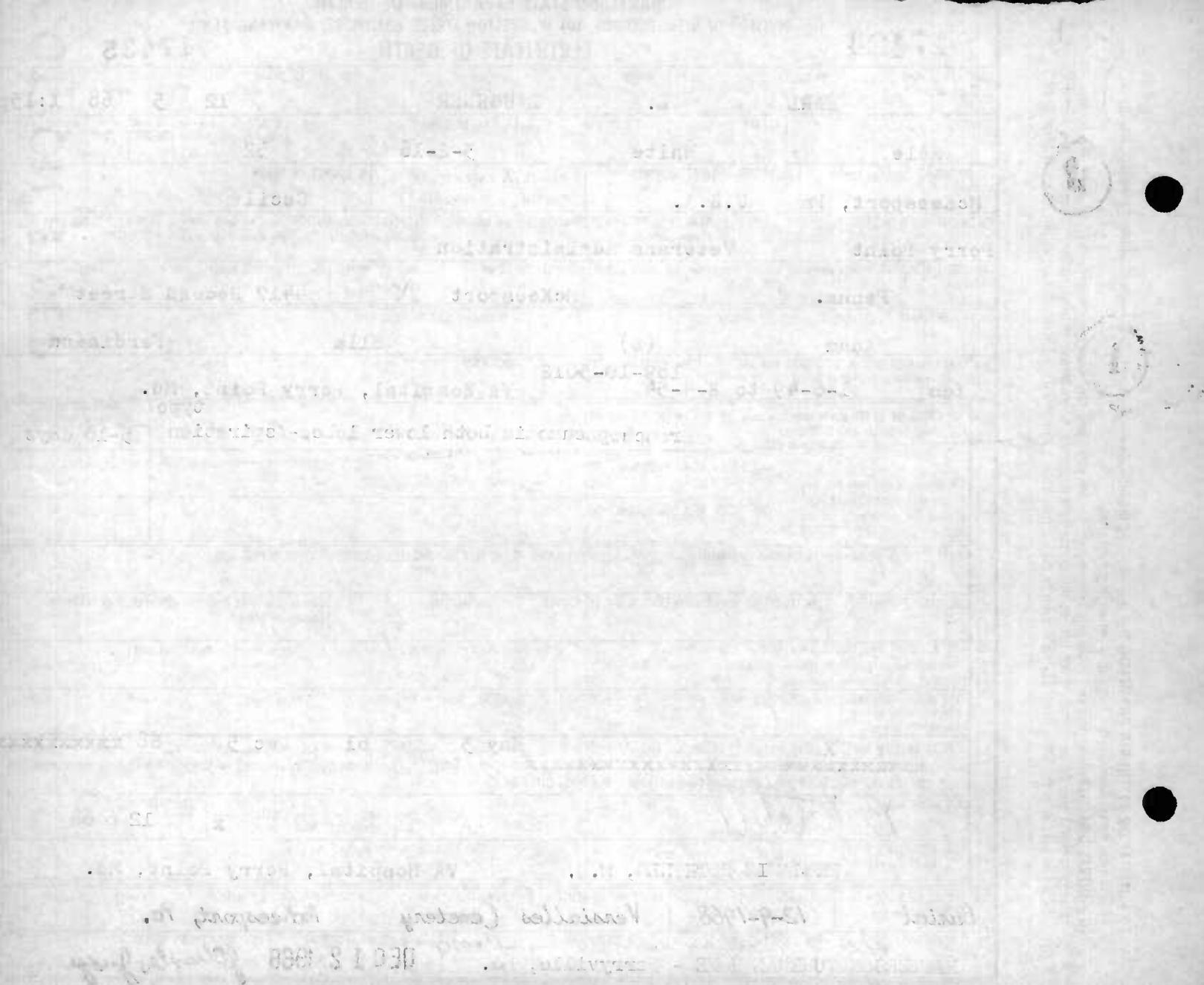
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED-NAME (Type or print)	First EARL	Middle L.	Lost LAUGHNER	20. DATE OF DEATH Month 12	2b. HOUR Doy 5	Year 68	
3. SEX Male	4. RACE White	S. DATE OF BIRTH 3-2-16			6. AGE (In years last birthday) 52		
7a. BIRTHPLACE (State or foreign country) McKeesport, Pa.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Cecil			Md.	
10. CITY OR TOWN OF DEATH Perry Point	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penns.	13c. CITY OR TOWN McKeesport	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 4417 Second Street				
14. FATHER'S NAME First Adam	Middle (D)	15. MOTHER'S MAIDEN NAME Ella	Middle Ferdinand			Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO. 189-10-5012	17. INFORMANT VA Hospital, Perry Point, Md.	Address			Type 5-10 days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia both lower lobes-Aspiration</b> 486X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 490X							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 3, 1961</b> , to <b>Dec 5, 1968</b> , <del>xxxxxx</del> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE <i>B. Rothfeld</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <b>12 6 68</b>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>VA Hospital, Perry Point, Md.</b>					
23a. BURIAL, CREMATION, BURIAL (Specify) <i>Burial</i>		23b. DATE <b>12-9-1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Versailles Cemetery</b>	23d. LOCATION (City or Town) <b>McKeesport, Pa.</b>			
24. FUNERAL DIRECTOR <i>See a Patterson &amp; Son</i>		ADDRESS <b>Patterson &amp; Son</b>	25a. REC'D BY REGISTRAR <b>Dec 12 1968</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
			DATE				



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

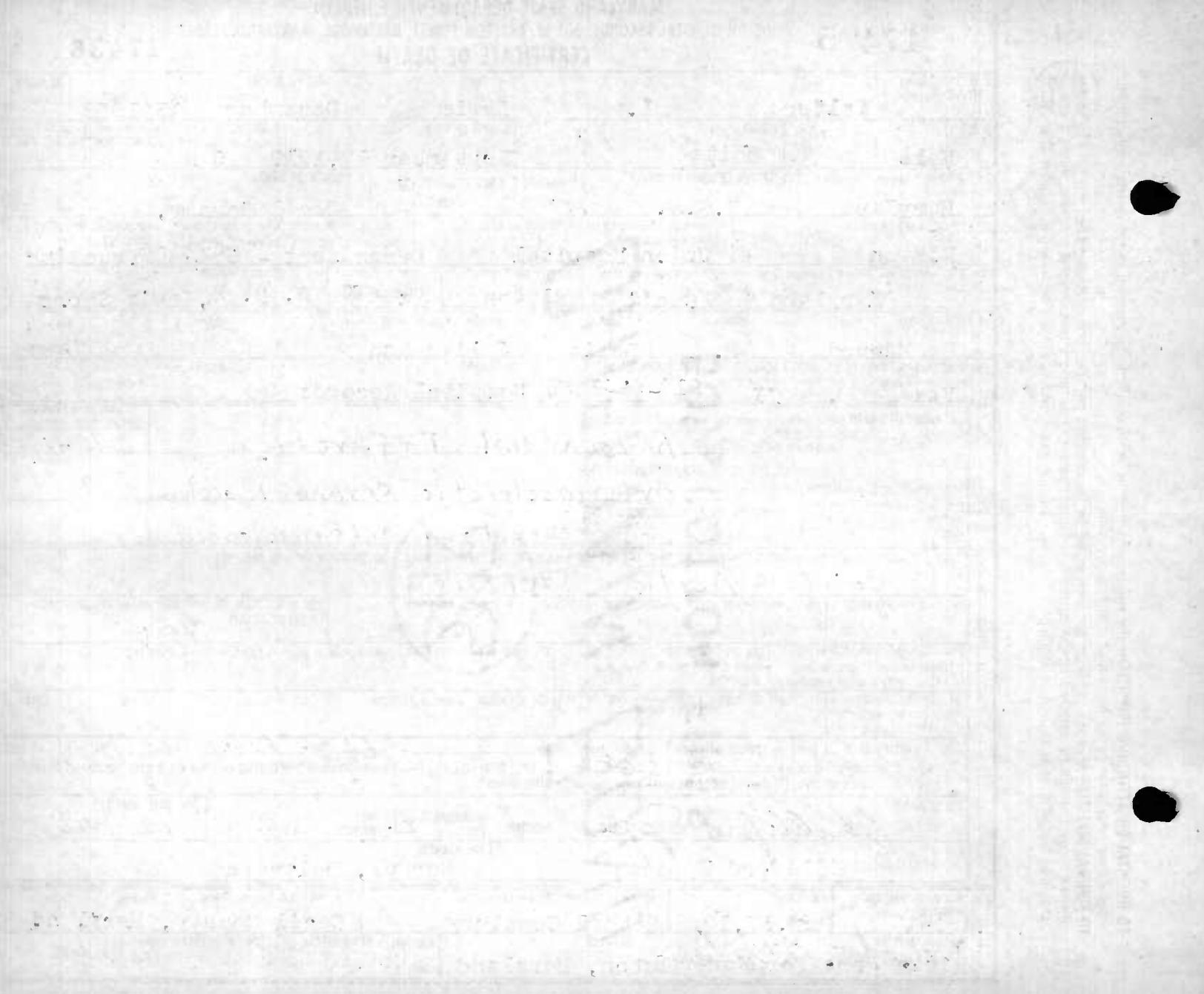
17425

17436

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages and 12 hours after death.

1. DECEASED-NAME (Type or print)	First Walter	Middle L.	Last Lewis	2. DATE OF DEATH Month December	Day 13	Year 1968	2b. HOUR M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH September 17 1919 49 yrs.		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS		
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED		9. COUNTY OF DEATH Cecil County		IF UNDER 24 MRS. MONTHS		
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired). President - Trucking/Drucking			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER R. D. 2, Lewis Shore				
14. FATHER'S NAME Edward	First F.	Middle Lewis	Last Julian Ann	15. MOTHER'S MAIDEN NAME Julian Ann	Address Laws			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. W W II	17. INFORMANT Hospital Records		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>				?				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 <u>Calciific Aortic Stenosis</u>								
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>1967</u> to <u>12-13, 1968</u> , that (I) (we) last saw the deceased alive on <u>12-13-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Williford Eppes</i>	22c. DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>12-14-68</u>				
22d. PHYSICIAN'S NAME (Type) Williford Eppes	22e. ADDRESS Newark, Delaware							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec 17, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) Cecil County, Maryland				
24. FUNERAL DIRECTOR <i>Teleph. E. Eppes</i>	ADDRESS Elkton, Maryland		25a. REC'D BY REGISTRAR DATE DEC 23 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17437

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Marlene	Middle E.	Last Mars	2a. DATE OF DEATH Month December	Day 3	Year 1968	2b. HOUR 6 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 2, 1941		6. AGE (in years last birthday) 27 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 168 Hollingsworth Manor		
14. FATHER'S NAME Arthur		First M.	Middle Murphy	Lost	15. MOTHER'S MAIDEN NAME Olive	First M.	Middle Wherry		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO.		17. INFORMANT Kenneth C. Mars, Elkton, Md.		Address			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY INFARCTION</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC CONGESTIVE HEART FAILURE</u> 2 yrs.</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>MYOMA OF THE HEART + ASD</u> 2-3 yrs.</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p><u>227X</u></p>									
19a. DATE OF OPERATION <u>227X</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 3, 1968</u> to <u>Dec. 3, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec. 3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Rolando A. Najera</u>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>12/3/68</u>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 105 E. Main St. Elkton, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/6/68		23c. NAME OF CEMETERY OR CREMATORIAL Elkton Cemetery		23d. LOCATION (City or Town) Elkton		(County) Md.	(State)
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u>		ADDRESS Hicks Home for Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



17427

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17438

Items 6 &amp; 8 FilmG408 1/10/69 ts CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First ETHEL	Middle Kennedy	Last MITCHELL	2a. DATE OF DEATH Month 12 Day 28 Year 68	2b. HOUR 9:45 AM
3. SEX FEMALE	4. RACE WHITE	S. DATE OF BIRTH 1879 12-2-1879	6. AGE (In years last birthday) 89 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) U.S.A.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH CECIL	
10. CITY OR TOWN OF DEATH RISING SUN MD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CALVERT HOSPITAL N. H.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13b. COUNTY HALFORD	13c. CITY OR TOWN Aberdeen	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Short Lane	
14. FATHER'S NAME James H. Kennedy M.D.	15. MOTHER'S MAIDEN NAME Ione Elliott				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO 215-56-4156	17. INFORMANT J1	Address Nancy M. Simons, Alexandria, Va 22311		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4379</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. <u>Cerebrovascular accident</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
(b) <u>Cerebral Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)				3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X					
19a. DATE OF OPERATION 331X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> At work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>6-7</u> , 19 <u>68</u> , to <u>12-27</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>12-27</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Neil R. Taylor</u>		22c. DATE SIGNED 12-28-68			
22d. PHYSICIAN'S NAME (Type) <u>Neil R. Taylor</u>		22e. ADDRESS <u>Rising Sun, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	23b. DATE 30 Dec 68	23c. NAME OF CEMETERY OR CEMETORY Grove Cemetery	23d. LOCATION (City or Town) Aberdeen, Maryland 21001	(County) Aberdeen, Maryland 21001	(State) Md.
24. FUNERAL DIRECTOR <u>James B. Largo</u>	ADDRESS Tarring Funeral Home Aberdeen, Maryland 21001	25a. REGISTRATION REGISTRATION DATE 1969	25b. REGISTRAR'S SIGNATURE <u>James B. Largo</u>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17428		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH										17439	
1. DECEASED-NAME (Type or print)		First		Middle		Lost		2a. DATE OF DEATH		2b. HOUR			
MARY ANN MUELLER								12 21		8 8 4:35 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN			
FEMALE		WHITE		9/15/1887		81							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
IOWA		US				CECIL							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
ELKTON		UNION		HOUSEWORK									
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
MD		CECIL		ELKTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		210 PARK CIRCLE					
14. FATHER'S NAME		First		Middle		Lost		15. MOTHER'S MAIDEN NAME		First			
WILLIAM LINDEMAD								CATHERINE GERLACH					
16a. WAS/DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
170		214-32-2470		RAYMOND MUELLER, ELKTON, MD						1 year			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SARCOMA, OVARY, WITH METASTASES DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO, OR AS A CONSEQUENCE OF lost. (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
1750		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from 12/9, 1968, to 12/21, 1968, that (I) (we) last saw the deceased alive on 12/20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE John A. Fischer, M.D.		22c. DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED 12/21/68			
22e. PHYSICIAN'S NAME (Type)		John A. Fischer		22e. ADDRESS		ECKTON, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12/23/1968		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) EASTON, MD		(County)		(State)			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR DEC 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					
MAURICE E. NEWMAN & SON, EASTON, MD													

26431

1980-1981

DEC 31 1980

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year	2b. HOUR 19 M
MARY			JOSEPHINE NEASE			OF ESTI- DEATH MATED <input type="checkbox"/>	19
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR 11:45 p.m.
female	white	Nov. 5, 1931	37 yrs.			December 30, 1968	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil	
Tennessee		U.S.A.					
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Practical Nurse	
						12b. KIND OF BUSINESS OR INDUSTRY Nursing	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER P.O. Box 45
14. FATHER'S NAME Ernest			15. MOTHER'S MAIDEN NAME Sims				
							ADDRESS Derting
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Clinton Ray Nease, Elkton, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO, OR AS A CONSEQUENCE OF 8199 Conditions, if any, which gave rise to immediate cause (a). stating the <u>underlying cause</u> (b) last. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8254							
MEDICAL CERTIFICATION	19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR AM 6:05 M 12/27/68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) involved in automobile accident		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) street		21f. LOCATION Street or R.F.D. No.		City or Town	County	State Cecil, Md.
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Werner U. Spitz</i>	EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	22b. DATE SIGNED 12/31/68
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/3/69	23c. NAME OF CEMETERY OR CREMATORY Pleasant Vale Cemetery			23d. LOCATION (City or Town) Green County, Tenn.	(County)	(State)
24. FUNERAL DIRECTOR <i>Ralph E. Hicks</i>	ADDRESS Hicks Home for Funerals, Elkton, Md.		25a. RECD BY REGISTRAR JAN 9 1969		25b. REGISTRAR'S SIGNATURE <i>Werner U. Spitz</i>		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

17430 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17441

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
MELVIN DERICKSON NUTTER						<input checked="" type="checkbox"/>	12	18	1968	9:18a	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	Month	Day	Year	2d. HOUR	
Male	White	Aug. 27, 1906	62 yrs.	MONTHS	DAYS	Month	Day	Year	1968	9:18a	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH							
Virginia	USA	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Cecil							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Elkton			Union Hospital			Merchant					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Del. New Castle			Newark			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1219 Nottingham Rd.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			17. INFORMANT		
First Middle Last			First Middle Last			(If yes give war or dates of service)			ADDRESS Newark, Del.		
Melvin D. Nutter			Carrie			Yes WW 2			Mrs. Viola F. Nutter 1219 Nottingham Rd		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (o) Arteriosclerotic cardiovascular disease											
4129 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (o). (b)											
stating the underlying cause last. (c)											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)											
4221											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
MATERIAL CERTIFICATION											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Edward F. Wilson, M.D.</i>											
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Dec. 21, 1968			23c. NAME OF CEMETERY OR CREMATORIAL Sharps Cem.			23d. LOCATION (City or Town) (County) (State) Fair Hill, Maryland		
24. FUNERAL DIRECTOR			ADDRESS <i>R.T. Louis Newark, Delaware</i>			25a. REC'D BY REGISTRAR DATE <i>DEC 23 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles J. Judd</i>		
VR A15ME (5) 10M REV. 1/68											



1  
FOR STATE  
HEALTH DEPT.N  
12/20/68  
17421

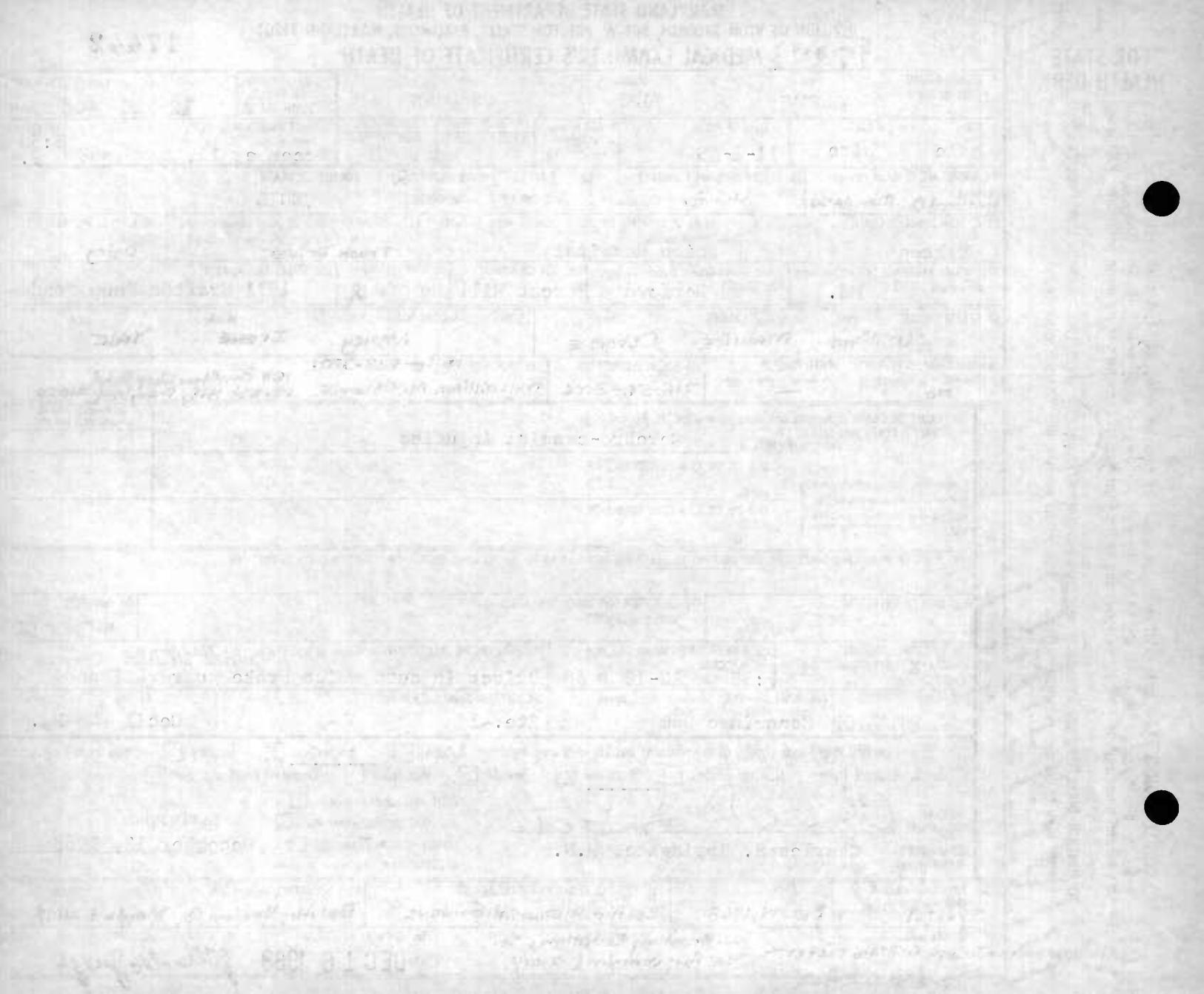
Item2a Film G107

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17442

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First THOMAS	Middle ALAN	Lost OSBORNE	2a. DATE KNOWN OF ESTI- DEATH MATED	Month 12	Day 10	Year 1968	2b. HOUR M
3. SEX Male	4. RACE White	S. DATE OF BIRTH 11-1-49	6. AGE (in years last birthday) 19 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month December Day 11 Year 1968			2d. HOUR 6:50 P.M.
7a. BIRTHPLACE (State or foreign country) Harford Co., Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CECIL			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY Dairy	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Harford		13d. INSIDE CITY LIMITS? Forest Hill		13e. STREET AND NUMBER 1811 Grafton Shop Road			
14. FATHER'S NAME William		Middle MAURICE	Lost Osborne	15. MOTHER'S MAIDEN NAME NANCY		First IRENE	Middle YALE	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 216-56-3006		17. INFORMANT Father 838-3821 Mr. William M. Osborne		ADDRESS 1811 Grafton Shop Road Forest Hill, Maryland 21050		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Cerebro-cranial injuries</u> 816.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (o), stating the <u>underlying cause</u> lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 2234									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOL 23M 7:35 P.M. 12-10 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) found in dam Driver in auto which broke guardrail and					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Conowingo Dam		21f. LOCATION Street or R.F.D. No. Rte. 1		City or Town Decil		County Md.	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles S. Springate, M.D.		22b. DATE SIGNED December 12, 1968							
EXAMINER'S NAME (Type)		22c. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE DEC 14, 1968		23c. NAME OF CEMETERY OR CREMATORIAL BEL Air Memorial Gardens		23d. LOCATION (City or Town) BEL Air, Harford Co., Maryland 21014		(County) (State)	
24. FUNERAL DIRECTOR Joseph William Foster		W. Broadway & Williams St. BEL Air, Maryland 21014		25a. REC'D BY REGISTRAR DATE DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 16. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form 413, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
17432 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17443

1. DECEASED-NAME (Type or Print)			First EARL	Middle THADDEUS	Last PICKELL	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 12/30	Month Year 1968	2b. HOUR 3:30 P.M.
3. SEX male	4. RACE white	S. DATE OF BIRTH Sept. 7, 1890	6. AGE (in years last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	MIN. HOURS 0	2c. DATE PRONOUNCED DEAD Month December Year 1968	2d. HOUR 4:30 P.M.
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil		
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tax Collector		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pennsylvania		13c. CITY OR TOWN Quarrysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.D. 3		
14. FATHER'S NAME Scott		Middle Pickell	Lost	15. MOTHER'S MAIDEN NAME Mary		16. SOCIAL SECURITY NO.		17. INFORMANT STATE Police "F", North EAST, Md
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		16c. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u></p> <p>4129 DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a).  stating the underlying cause <u>last</u> (b) _____</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) _____</p>								
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>4221</p>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
<p>22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <u>Werner U. Spitz</u></p> <p>EXAMINER'S NAME (Type) Werner U. Spitz, M.D.</p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></p> <p>ADDRESS (Street, city, town, or county)</p>								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/2/69		23c. NAME OF CEMETERY OR CREMATORIAL New Hampshire U.C.C.		23d. LOCATION (City or Town) Elkton		
24. FUNERAL DIRECTOR Raef E. Hicks		ADDRESS Hicks Home, just outside Elkton, Maryland		25a. REC'D BY REGISTRAR DATE JAN 9 1969		25b. REGISTRAR'S SIGNATURE Raef E. Hicks		



17433

Item 1 Film 408 1/17/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17444

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First William Henry H.	Middle Purdy, Jr.	Lost	2a. DATE OF DEATH Month 12	Doy 20	Year 68	2b. HOUR 11:50 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Sept. 11, 1894	6. AGE (In years last birthday) 74	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil					
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U.S. Government C&D Canal	12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland	lived, if institution: Residence before 13b. COUNTY Cecil	13c. CITY OR TOWN Chesapeake City	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Cecil St.				
14. FATHER'S NAME William Henry Purdy	15. MOTHER'S MAIDEN NAME Mary			Middle A.	Last Way			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. WV 1	17. INFORMANT Mrs. Ethel D. Purdy, Chesapeake City	Address Md:					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Coronary Occlusion</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Hypertensive C.V. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR SEVERAL YEARS				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4201								
19a. MEDICAL CERTIFICATION NONE	19b. DATE OF OPERATION NONE	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Doy Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that (I) (this hospital) attended the deceased from <u>DEC 17 1968</u> to <u>DEC 20 1968</u> , that (I) (we) last saw the deceased alive on <u>DEC 20 1968</u> and that in (my) ( <input type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Henry V. Davis MD</u>	22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED 12/30/68						
22d. PHYSICIAN'S NAME (Type) Henry V. Davis MD	22e. ADDRESS CHESAPEAKE CITY MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/24/68	23c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery	23d. LOCATION (City or Town) (County) Bethel, Cecil	(State) Md.				
24. FUNERAL DIRECTOR Ralph E. Hicks	ADDRESS Hicks Home for Funerals, Elkton, Md.	25a. REC'D BY REGISTRAR DATE DEC 31 1968	25b. REGISTRAR'S SIGNATURE Charles Judge					



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17445

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and ~~completely~~ filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Mary	Middle Esther Rawlings	Last 12	2a. DATE OF DEATH Month 7 Day 68 Year	2b. HOUR 4:55 P.M.
3. SEX Female	4. RACE white	5. DATE OF BIRTH 2/6/84	6. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil		
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital of Cecil Co.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Secretary Ret. Y.M.C.A.	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.	13b. COUNTY Cecil	13c. CITY OR TOWN Port Deposit	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.F.D. #1	
14. FATHER'S NAME Robert K.	First Rawlings	Middle Sarah	Last Maxwell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. 219-30-5403	17. INFORMANT Robert Rawlings	Address Port Deposit		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4339 DUE TO, OR AS A CONSEQUENCE OF Cerebral thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic heart disease and peripheral vascular disease					
19a. DATE OF OPERATION 11/2/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Thrombosis, popliteal artery	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Oct 6, 1968, to Dec. 7, 1968, that (I) (we) last saw the deceased alive on Dec. 7 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edgar E. Folk III, M.D.					
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS 1155 Ave. "A" Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-10-1968	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hopewell Cem.	23d. LOCATION (City or Town) Port Deposit	(County) Cecil Co.	(State)
24a. FUNERAL DIRECTOR Name John E. McMullen	24b. ADDRESS Rising Sun	25a. REC'D BY REGISTRAR DATE DEC 12 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17435

## CERTIFICATE OF DEATH

17446

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 Page 4 may be retained by the hospital or attending physician.

3 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>20 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		d. STREET ADDRESS <b>RD# 2 Locust Point</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First <b>Cornelius</b> Middle <b>F. SHANAHAN</b>		4. DATE OF DEATH Month <b>12</b> Day <b>14</b> Year <b>1968</b>	
5. SEX <b>Male</b> 6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>1/22/06</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		10. KIND OF BUSINESS OR INDUSTRY <b>Plumber</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Shanahan</b>		14. MOTHER'S MAIDEN NAME <b>Mamie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>WWII</b>		16. SOCIAL SECURITY NO. <b>555-01-7734</b>	
17. INFORMANT <b>Mrs. Cornelius F. Shanahan-above</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suspected myocardial infarction</b> DUE TO <b>4109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCLD</b> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , 19, to <b>present</b> , 19, that (I) (we) last saw the deceased alive on <b>Nov 19 68</b> , and that death occurred at <b>11:15 P.M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>12/14/68</b>	
22a. SIGNATURE <b>Robert L. Gray</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Robert L. Gray, MD.</b>		22d. ADDRESS <b>123 W. High St. Elkton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/18/68</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Riverview Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>XXXX Wilmington, N.C. Del.</b>	
24. FUNERAL DIRECTOR <b>PIPPIN FUNERAL HOME, Elkton, Md.</b>		25a. ADDRESS <b>ELKTON, MD.</b>	
		25b. REC'D. BY REGISTRAR DATE <b>DEC 23 1968</b>	
		25c. REGISTRAR'S SIGNATURE <b>Alma L. Gray</b>	



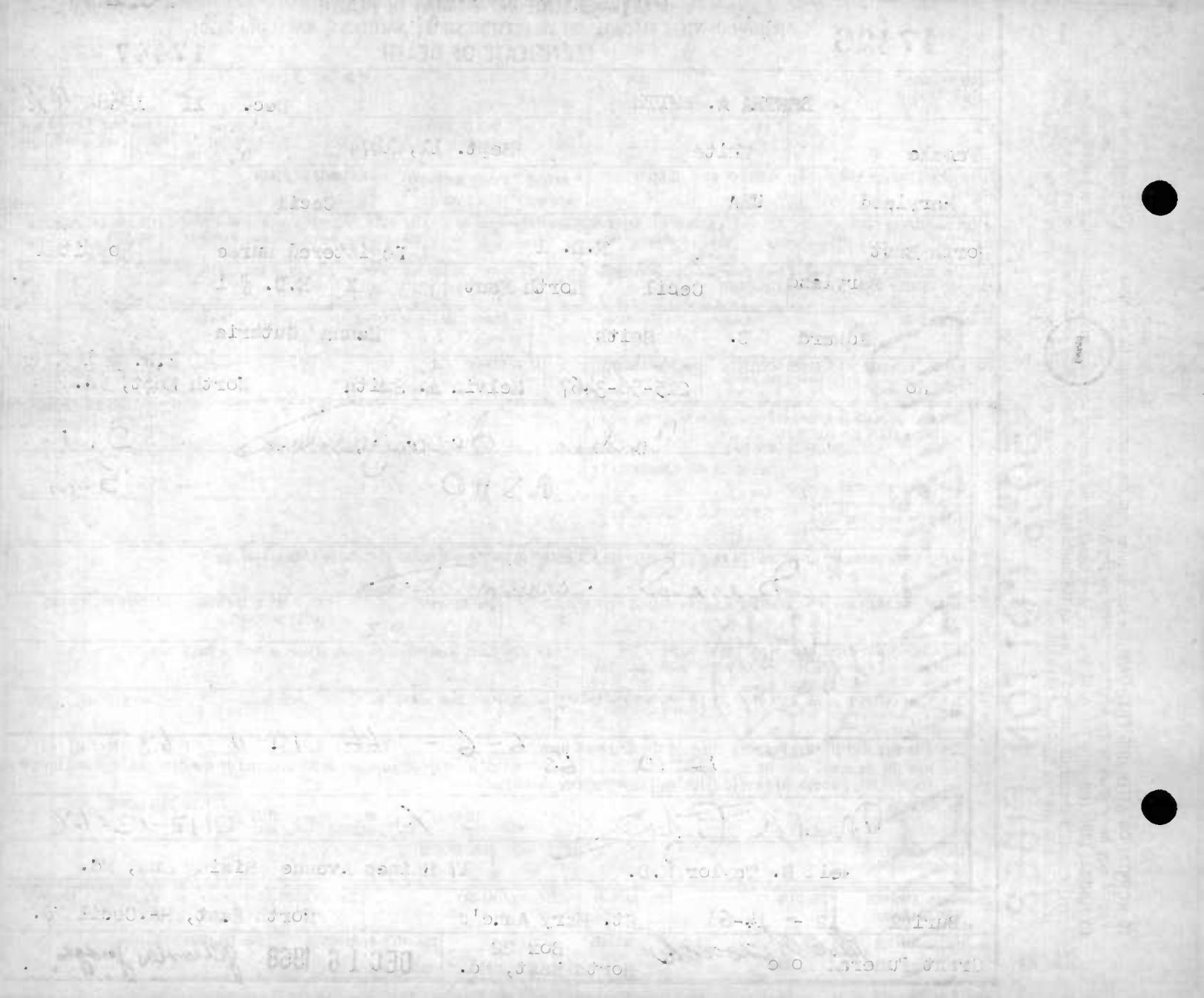
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17436

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17447

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the hospital or attending physician, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 10:30 A.M.	
BERTHA A. SMITH				Dec. 11 1968		
3. SEX Female	4. RACE White	5. DATE OF BIRTH Sept. 11, 1874		6. AGE (In years last birthday) 94 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil			
10. CITY OR TOWN OF DEATH North East	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.D. 1	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Registered nurse	12b. KIND OF BUSINESS OR INDUSTRY Hospital			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN North East	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.D. # 1	Md.	
14. FATHER'S NAME First Edward	Middle B.	Last Smith	15. MOTHER'S MAIDEN NAME Hanna Guthrie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 215-56-3467	17. INFORMANT Melvin A. Smith	Address R.D. # 1 North East, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Condrieu</i> <i>Demijessamine</i> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> <i>ASHO</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4200 <i>Benzodiazepines</i> <i>carbamazepine</i>						
19a. DATE OF OPERATION 2	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Benzodiazepines</i> <i>carbamazepine</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 6-6-1966, to 12-11-1968, that (I) (we) last saw the deceased alive on 12-10-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Neil R. Taylor</i>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 12-13-68	
22d. PHYSICIAN'S NAME (Type) Neil R. Taylor M.D.		22e. ADDRESS 17 Haines Avenue Rising Sun, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12 - 14-68	23c. NAME OF CEMETERY OR CREMATORIAL St. Mary Anne's	23d. LOCATION (City or Town) North East, Md.	(County) Cecil	(State) Md.	
24. FUNERAL DIRECTOR Grant Funeral Home	ADDRESS Box 22 North East, Md.	25a. REC'D BY REGISTRAR DEC 16 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17448

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First  Lyman	Middle  A.	Last  Spence	2a. DATE OF DEATH Month 12	2b. HOUR Day 5 Year 1968 8:41 AM
3. SEX		4. RACE  Male White		5. DATE OF BIRTH  March 31, 1883		6. AGE (In years last birthday) 85 YRS.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED		9. COUNTY OF DEATH Cecil
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Florist		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 101 Stockton St.
14. FATHER'S NAME George		First R.	Middle Spence	15. MOTHER'S MAIDEN NAME Anna		Middle Last Maria McCullough
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 213-12-0928		17. INFORMANT Mrs. Ralph E. Hicks, Elkton, Md.		Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200						
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1. <u>Ca ascending colon &amp; liver metastases.</u> 2. <u>Anemia, severe, malabsorption</u>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>11-30-1968</u> to <u>12-2-1968</u> , that (I) (we) last saw the deceased alive on <u>12-2-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Tillman D. Johnson</u>		22c. DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>12-5-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson M.D.</u>		22e. ADDRESS <u>123 S. Market St., Elkton, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/9/68	23c. NAME OF CEMETERY OR CREMATORIAL Cherry Hill Meth. Cemetery, Cherry Hill, Md.	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Ralph E. Hicks		ADDRESS Hicks Home for Funerals, Elkton, Md.	25a. REC'D BY REGISTRAR DATE DEC 13 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17449

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <b>DEE</b>	Middle <i>Chancy</i>	Lost <b>SULLIVAN</b>	2a. DATE OF DEATH Month <b>12</b> Day <b>11</b> Year <b>68</b>	2b. HOUR 11:20 pm		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>2-2-16</b>		6. AGE (In years at birthday) <b>52</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Cecil</b>		
10. CITY OR TOWN OF DEATH <b>Perry Point</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Veterans Administration</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Bel Air</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RD #2, Box 298</b>
14. FATHER'S NAME First <b>James</b>		Middle <b>Wilson</b>	Lost <b>Sullivan (L)</b>	15. MOTHER'S MAIDEN NAME First <b>Anna</b>		Middle <b>Mae</b>	Lost <b>Sturgill (L)</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT <b>VA Hospital records, Perry Point, Md.</b>		Address		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unknown</b></p> <p>5339</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</p> <p>(b) <b>Peptic ulcer</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) <b>Prostatitis</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>								
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)</p> <p>5400</p>								
19a. DATE OF OPERATION <b>5400</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION	Street or R.F.D. No.	City or Town	County	State
<p>22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 3, 1968</b>, to <b>Dec. 11, 1968</b>, <del>and that (my) (our) opinion</del> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>								
22b. SIGNATURE <i>S. Goldgraben</i>		DEGREE	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>12-12-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>S. GOLDGRABEN, M.D.</b>		22e. ADDRESS <b>VA Hospital, Perry Point, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>DEC 15, 1968</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Sullivan Family Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>LANSING ASHE CO., NORTH CAROLINA 28643</b>		
24. FUNERAL DIRECTOR <i>John Franklin Foster</i>		ADDRESS <b>W. Broadway</b>		25a. REC'D. BY REGISTRAR DATE <b>DEC 16 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
<p>Foster Funeral Home, Bel Air, Md. 21014</p>								

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17450

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First <b>CLYDE</b>	Middle <b>V.</b>	Lost <b>THREATT</b>	20. DATE OF DEATH Month <b>12</b> Day <b>19</b> Year <b>68</b>	2b. HOUR <b>12:45M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>	5. DATE OF BIRTH <b>12-11-11</b>		6. AGE (In years at birthday) <b>57</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Cecil</b>		
10. CITY OR TOWN OF DEATH <b>Perry Point</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Veterans Administration</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>New Jersey</b>		13b. COUNTY	13c. CITY OR TOWN <b>Camden</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>2053 Westminster Avenue</b>		
14. FATHER'S NAME First <b>Vanass</b>		Middle <b>Threatt</b>	Lost	15. MOTHER'S MAIDEN NAME First <b>Hattie</b>	Middle	Last <b>Magum</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II 294-03-0737</b>		17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) (Trachea & Bronchi) by food particle							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Complete obstruction of air passageways</b> APPROXIMATE INTERVAL 3451 ONSET AND DEATH sudden							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) <b>Recurrent epileptic seizures</b>							
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Skull fracture, old (1952) following a seizure</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. <b>19</b> P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) <b>At home, Farm, Street, Factory, Office Building, etc.</b>		21d. LOCATION Street or R.F.D. No. <b>19</b> City or Town <b>Camden</b> County <b>Camden</b> State <b>N.J.</b>		
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. PLACE OF INJURY					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 22, 1957</b> , to <b>Dec. 19, 1968</b> , <b>XXXXXX</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>A. L. Mooney, M.D.</b>		22c. DEGREE <b>M.D.</b>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>12-20-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY, M.D.</b>		22e. ADDRESS <b>VAH, Perry Point, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12-21-1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Forest Lawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Charlotte, N.C.</b>		
24. FUNERAL DIRECTOR <b>Lee A. Patterson &amp; Son, Perryville, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 30 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



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MARYLAND STATE DEPARTMENT OF HEALTH

Item 8 FilmG407 12/23/68 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17451

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or offending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First Raymond	Middle R.	Lost Zentz	2a. DATE OF DEATH Month December	17451	2b. HOUR 1:16 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH May 27, 1900		6. AGE (in years last birthday) 68	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Illinois	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil	Md.		
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Golf Course	12b. KIND OF BUSINESS OR INDUSTRY --		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 118 West Main St.		
14. FATHER'S NAME Allen	First Middle Zentz	15. MOTHER'S MAIDEN NAME Catherine	16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
16b. SOCIAL SECURITY NO. 410-9				17. INFORMANT Mrs. Estelle P. Zentz, Elkton, Md.	Address Groth	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs. -		
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c)				8 hrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201						
19a. DATE OF OPERATION X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Dec. 26, 1963 to Dec. 7, 1968, that (I) (we) last saw the deceased alive on Dec. 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Raymond S. Zentz		22c. DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 12/10/68	
22d. PHYSICIAN'S NAME (Type) Joseph G. Lanzi		22e. ADDRESS Elkton Medical Park, Elkton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/12/68	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National	23d. LOCATION (City or Town) Baltimore, Md.	(County)	(State)
24. FUNERAL DIRECTOR Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 13 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

